

# 2011 Military Health System Conference

## Ventilator Associated Pneumonia: Targeting Zero

*The Quadruple Aim: Working Together, Achieving Success*

Stephen M. Yamada MS, CIC

January 25, 2011



Tripler Army Medical Center  
Honolulu, Hawaii

Report Documentation Page				Form Approved OMB No. 0704-0188	
Public reporting burden for the collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to a penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.					
1. REPORT DATE <b>25 JAN 2011</b>		2. REPORT TYPE		3. DATES COVERED <b>00-00-2011 to 00-00-2011</b>	
4. TITLE AND SUBTITLE <b>Ventilator Associated Pneumonia: Targeting Zero</b>				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S)				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) <b>Tripler Army Medical Center, Honolulu, HI, 96859</b>				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)				10. SPONSOR/MONITOR'S ACRONYM(S)	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION/AVAILABILITY STATEMENT <b>Approved for public release; distribution unlimited</b>					
13. SUPPLEMENTARY NOTES <b>presented at the 2011 Military Health System Conference, January 24-27, National Harbor, Maryland</b>					
14. ABSTRACT					
15. SUBJECT TERMS					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT <b>Same as Report (SAR)</b>	18. NUMBER OF PAGES <b>11</b>	19a. NAME OF RESPONSIBLE PERSON
a. REPORT <b>unclassified</b>	b. ABSTRACT <b>unclassified</b>	c. THIS PAGE <b>unclassified</b>			

# Tripler Army Medical Center



## **-239 bed Tertiary Care facility**

\*264,000 local active duty, retiree, family members, VAB

\*171,000 referral population

## **Adult Intensive Care Unit**

-15 bed medical/surgical ICU

-Average census: 11.5 beds/day

- Average LOS: 3.1 days

-Average ventilator days/month: 116

# Technical Work



- Addresses problems for which the definition is clear, the potential solutions are reasonably clear and usually require little or minimal learning
  - Institute for Healthcare Improvement bundle
  - Silver coated endotracheal tube
  - Reinforced the ABC weaning protocol
  - New closed suctioning system



# Adaptive Work



- Addresses problems that require a change in attitudes, beliefs, and behavior
- Involves shared responsibility for change: leaders share responsibility with organizational staff and key stakeholders
- Most common error
  - Treating an adaptive problem as technical



# Comprehensive Unit-Based Safety Program (CUSP)



Improve safety culture & learn from mistakes  
by integrating safety practices

# How can we improve



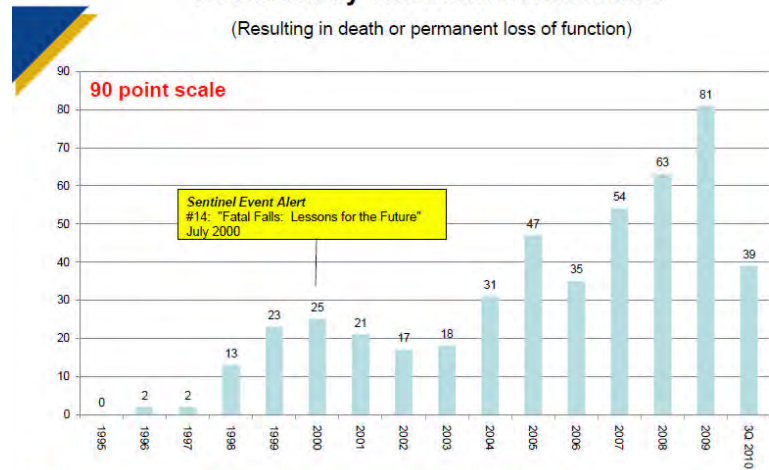
“Every system is perfectly designed  
to achieve the results it gets”

# Sentinel Event Data



## Fall-related Events Reviewed by The Joint Commission

(Resulting in death or permanent loss of function)



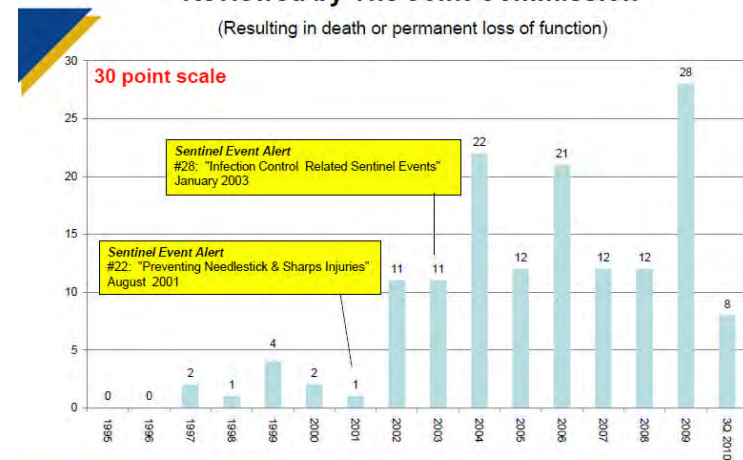
The Joint Commission

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

Office of Quality Monitoring - 11

## Infection-related Events Reviewed by The Joint Commission

(Resulting in death or permanent loss of function)



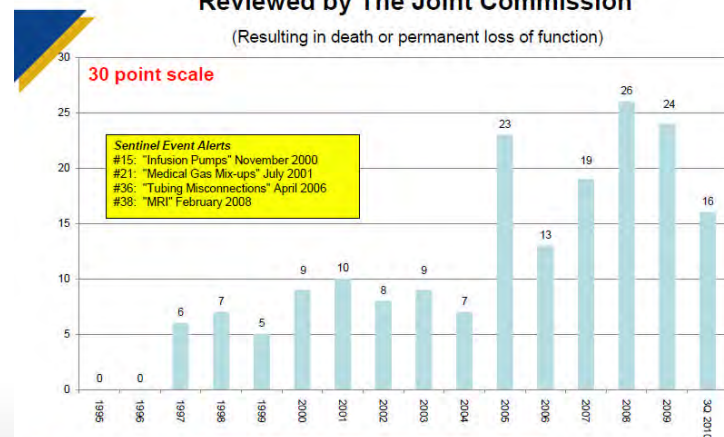
The Joint Commission

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

Office of Quality Monitoring - 14

## Medical Equipment-related Events Reviewed by The Joint Commission

(Resulting in death or permanent loss of function)



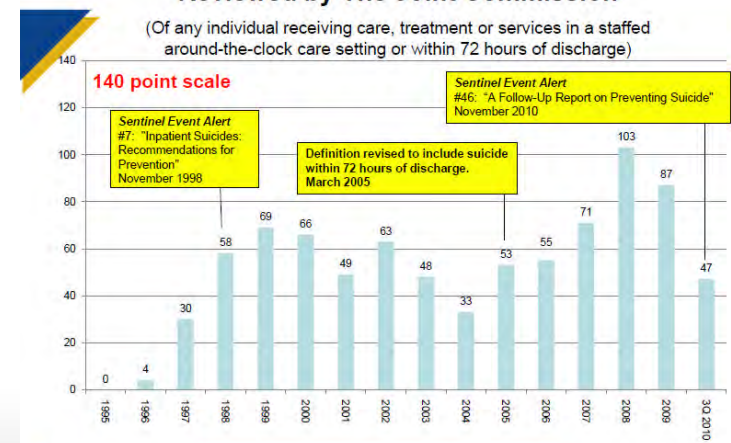
The Joint Commission

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

Office of Quality Monitoring - 17

## Suicide Events Reviewed by The Joint Commission

(Of any individual receiving care, treatment or services in a staffed around-the-clock care setting or within 72 hours of discharge)



The Joint Commission

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

Office of Quality Monitoring - 25



# Steps of CUSP



- Educate staff on Science of Safety
- Identify defects
  - Clinical or operational that you do not want to happen again
- Assign executive to adopt unit
  - Communication, attitudes, resources
- Learn from one defect per quarter
- Implement teamwork tools

# So where are we now...



# Summary



- Is a continuous process
- No longer just an “unfortunate” occurrence
- No longer satisfied to be below the national mean
  - Mean anchored us to mediocre performance
- Goal now is to strive for “zero”



# MAHALO!

(Thank you!)

